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Allowable FQHC costs for each category of other ambulatory services shall be determined in accordance with Medicare reasonable cost principles as set forth in 42 CFR Part 413 and Medicare FQHC allowable cost principles set forth in 42 CFR 405.2468, and HCFA manual provisions applicable to FQHCs, including the Medicare provider reimbursement manual, HCFA Pub. 15 and HCFA Pub.27

(B.) X SUPPLEMENTAL PAYMENTS FOR MENTAL HEALTH SERVICES AND/OR HEALTH MAINTENANCE ORGANIZATION SERVICES

In accordance with Section 4712(b) (1) (B) of the Balanced Budget Act of 1997, the department will make payments to FQHCs at least quarterly, of a supplemental payment equal to the amount, if any, by which the rates payable to the FQHC by the Montana Medicaid program exceeds the amounts paid to the FQHC by managed care organizations and/or health maintenance organizations for services provided to Medicaid recipients. The department will request documentation from the providers of the type of services provided, the mental health or HMO payment amount per service made to provider, the number of visits provided, the provider's Medicaid reimbursement rate or amount for each type of service, total amount of the supplemental payment due to the provider, along with the recipient name, social security number and date of service. This notice will be sent to providers 20-30 days prior to the end of each quarter. The department will make payments due to providers, if any, within 30 days of receipt of the above information from the provider. If no information is provided to the department from the provider, this will be interpreted that no request for payment is being pursued.

(C.) X RECONCILIATION AND SETTLEMENT OF INTERIM RATE PAYMENTS

All FQHC providers are reimbursed on an interim basis until actual cost and visit or charge data is available. Final reimbursement rates are then determined based upon the actual data, and the difference between the interim and final rates is reconciled and settled. Because final reimbursement rates or amounts may not be available at the time supplemental payments are made, these payments also must be reconciled and settled upon determination of final rate or reimbursement amounts. This assures that providers are reimbursed based upon actual cost, charge and/or visit data, so that the department can assure compliance with the federal requirement that providers are reimbursed 100 percent of reasonable cost.

MONTANA

I. Reimbursement for X-Ray Services shall be:

A. The lower of:

1. The provider's usual and customary charge for the service; or

2. Reimbursement provided for those Resource Based Relative Value Scale (RBRVS) fees provided and reimbursed for under Attachment 4.19B, Methods & Standards For Establishing Payment Rates for Service 5(a), Physicians' Services.

II. Reimbursement for Laboratory Services shall be:

A. The lower of:

1. The provider's usual and customary charge for the service;

2. 60% of the National Cap Fee (for non-exempt procedures established under Medicare); or

3. Where there is no Medicare fee assigned, at "By-Report." 'By report' means paying a percentage of billed charges. The percentage is derived by dividing the previous state fiscal year's total Medicaid reimbursement for services included in the RBRVS by the previous state fiscal year's total Medicaid billings.

Attachment 4.19B
Methods and Standards
for Establishing
Payment Rates for
Chiropractic Services

MONTANA

I. Reimbursement for Chiropractic Services under the QMB Program shall be the lowest of the following:

A. The provider's actual (submitted) charge for the service;

B. The amount allowable for the same service under Medicare; or

C. The Department's fee schedule.

II. In determining upper limits of reimbursement for Chiropractic Services:

A. The provider's actual charge is the amount submitted on the claim to Medicaid.

B. The amount allowable for the same service under Medicare is obtained from the Medicare Part B Carrier.

C. The Department's fee schedule.

- Medicaid reimbursement for chiropractic service is the Medicare fee in effect July 1, 1989.

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The Department will reimburse Medicaid providers for EPSDT services based on the lower of:

1. the provider's actual charge for the service; or
2. the Department's fee schedule (where the Department has not established a fee schedule, a rate negotiated with the provider):

a. Specific fee per selected procedure:

Any procedure not assigned an RVU through RBRVS exceeding 50 occurrences within a 12 month period will have a fee established at 65.2% of average billed charges.

Once the fee is established, any increase in reimbursement must be authorized through legislation.

b. Percent of billed charges per selected procedures:

Any procedure not assigned an RVU through RBRVS having fewer than 50 occurrences within a 12 month period are reimbursed at 65.2% of billed charges.

c. Resource-based Relative Value system

Non-institutional services using HCPC codes will have a payment level established based on a Resource-based Relative Value Scale using the current Resource-base Relative Value System.

MONTANA

I. Reimbursement for Family Planning Services shall be the lower of the following:

A. For physicians:

1. The provider's usual and customary charge for the service; or

2. Those fees provided and reimbursed for under Attachment 4.19B, Methods & Standards for Establishing Payment Rates for Service 5(a), Physicians' Services.

B. For mid-level practitioners:

1. The provider's usual and customary charge for the service; or

2. Those fees provided and reimbursed for under Attachment 4.19B, Methods & Standards for Establishing Payment Rates for Service 5(a), Physicians' Services.

MONTANA

I. Reimbursement for Physician Services shall be:

A. The lower of:

1. The provider's usual and customary charge for the service; or

2. Reimbursement provided in accordance with the methodology described in Number II.

II. The Department's fee schedule for Physician Services is determined:

A. In accordance with the Resource Based Relative Value Scale (RBRVS) methodology, by multiplying Medicare's Relative Value Units (RVU), which is numeric, by the Montana Medicaid specific conversion factor, which is a dollar amount, to equal a fee. Specific to Montana Medicaid, there is an ability to multiply the fee times a policy adjuster (either plus or minus) to affect the fee including but not limited to:

1. For state fiscal year 1998, no less than 85% of and nor more than 140% of the Medicaid fee for that procedure in state fiscal year 1997;

2. For state fiscal year 1999, no less than 80% of and nor more than 145% of the Medicaid fee for that procedure in state fiscal year 1997.

B. If there is not a Medicare RVU, Montana Medicaid will utilize history data to convert to an RVU.

C. For anesthesia services, by multiplying the sum of Medicare's anesthesia base units and applicable time

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units, which is numeric, by the Montana Medicaid specific anesthesia conversion factor, which is a dollar amount, to equal a fee.

D. For laboratory services with Medicare fees, as those fees provided and reimbursed for under Attachment 4.19B Methods & Standards For Establishing Payment Rates for Service 3 Laboratory & X-ray Services.

E. If there is not a Medicare RVU or Medicaid history data, Medicare Anesthesia Base Unit or Medicare Laboratory Fee reimbursement will be `by report'. `By report' means paying a percentage of billed charges. The percentage is derived by dividing the previous state fiscal year's total Medicaid reimbursement for services included in the RBRVS by the previous state fiscal year's total Medicaid billings.

Service 6(a)
Podiatrist Services

MONTANA

I. Reimbursement for Podiatrist Services shall be the lower of:

A. The provider's usual and customary charge for the service; or

B. Those fees provided and reimbursed for under Attachment 4.19B, Methods & Standards for Establishing Payment Rates for Service 5(a), Physicians' Services.

Attachment 4.19B,
Methods & Standards for
Establishing Payment Rates,
Service 6.b,
Optometrists' Services

MONTANA

I. Reimbursement for Optometric Services shall be:

A. The lower of:
1. The provider's * usual and customary charge for the service; or
2. Reimbursement provided in accordance with the methodology described in Number II.

II. The Department's fee schedule for Optometric Services is determined:

A. In accordance with the Resource Base Relative Value Scale (RBRVS) methodology, by multiplying Medicare's Relative Value Units (RVU), which is numeric, by the Montana Medicaid specific conversion factor, which is a dollar amount, to equal a fee. Specific to Montana Medicaid, there is an ability to multiply the fee times a policy adjuster (either plus or minus) to affect the fee including:
1. For state fiscal year 1998, no less than 85% of and nor more than 140% of the Medicaid fee for that procedure in state fiscal year 1997;
2. For state fiscal year 1999, no less than 80% of and nor more than 145% of the Medicaid fee for that procedure in state fiscal year 1997.

B. If there is not a Medicare RVU, Montana Medicaid will utilize history data to convert to an RVU.

C. If there is not a Medicare RVU or Medicaid history data, reimbursement will be 'by report'. 'By report' means paying a percentage of billed charges. The percentage is derived by dividing the previous state fiscal year's total Medicaid reimbursement for services included in the RBRVS by the previous state fiscal year's total Medicaid billings.

* A provider is an optometrist licensed in the State of Montana who is individually enrolled in the Montana Medicaid program.

Attachment 4.19B,
Methods & Standards
for Establishing
Payment Rates,
Service 6.d,
Clinical Social
Workers' Services

MONTANA

I. Reimbursement for Clinical Social Workers' Services shall be the lowest of the following:

A. For those services not also covered by Medicare:

1. the provider's actual (submitted) charge for the services; or
2. the Department's fee schedule.

B. For those services also covered by Medicare:

1. the provider's actual (submitted) charge for the service;
2. the amount allowable for the same service under Medicare; or
3. the Department's fee schedule.

II. In determining upper limits of reimbursement for Clinical Social Workers' Services:

A. The provider's actual charge is the amount submitted on the claim to Medicaid.

B. The amount allowable for the same service under Medicare is obtained from the Medicare Part B Carrier.

C. The Department's fee schedule has two components:

1. Specified fees per selected procedure:

Procedures for which there is a statistically significant volume* during th calendar year preceding the fiscal review year have specified fees established.

2. Percentage of billed charges per selected procedure:

Procedures for which there is not a statistically significant volume or with variable modifiers reflecting exceptional difficulty are reimbursed at 65.2% of billed charges.